Communiversity

Mental Health Crisis Services Monograph: Examining the Condition of Mental Health Crisis Services in Minnesota and Beyond

Prepared in partnership with
National Alliance on Mental Illness (NAMI) of Minnesota

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EXECUTIVE SUMMARY

Occurring in all age groups and populations, mental illness remains among the most frequent health concerns in the United States. In recent years, emergency mental health service provision has evolved beyond traditional hospital and police based intervention and assessment to include more comprehensive and tailored systems of care. Prime among this evolved system of care are mobile mental health crisis services. These services seek to address a wide variety of consumer needs, from initial assessment and referral to stabilization and after-care. In Minnesota, emergency mental health services vary greatly by locale despite state legislation which seeks to standardize and provide crisis services, and access to and awareness of such services remain low. Moreover, training for relevant professionals (such as police and EMTs) often fails to adequately prepare these service providers to effectively deal with mental health emergencies. Current system needs are assessed by way of literature review, analysis of extant data, and interviews with persons relevant to specific areas of service. Crisis service systems from outside of Minnesota are likewise assessed and recommendations for changes to services in Minnesota are made based on these other service models as well as best-practice standards.

Mental Health Crisis Services Monograph: Examining the Condition of Mental Health Crisis Services in Minnesota and Beyond

In the United States, approximately one in four adults have a diagnosable mental illness in a given year, with about six percent of American adults suffering from a serious mental illness. The frequency of mental illness makes it the number one cause of disability in North America (NIMH, 2006). Moreover, symptoms of a mental disorder are second only to respiratory disease in the frequency of their presentation in outpatient health care (National Center for Health Statistics, 1997). The combined direct and indirect costs of mental illness to the United States economy is over $150 billion annually (National Advisory Mental Health Commission, 1993; U.S. Dept. of Health and Human Services, 1999). The estimate of indirect costs of mental illness, which was last computed to be approximately $80 billion in 1990, is a conservative estimate. Given the date of the estimate, as well as its conservative scope, the actual current indirect economic impact of mental illness likely far exceeds $80 billion annually (National Advisory Mental Health Commission, 1990).

The impact of mental illness is felt no less in Minnesota. A stratified random sample of Minnesota residents found that over 300 thousand adults had significant depressive symptoms in 2005, with nearly 95,000 experiencing symptoms of a severe mental illness (McAlpine, Beebe, McCoy, & Davern, 2006). Additionally, mental illness significantly impacts the state economy, both through direct costs to consumers, health care providers, schools, prisons, and a wide variety of social

services, as well as through indirect costs which permeate throughout the state economy (Minnesota Department of Human Services, 2007). Specifically concerning government, it is estimated that mental health care accounts for nearly 20% of health care expenditures made by state and local governments (National Advisory Mental Health Commission, 1993). Much of the costs related to mental illness in Minnesota result from a health care system which often fails to effectively prevent escalation of mental illness. In 2007, a state mental health initiative identified Minnesota's system of care as fragmented and unfocused on early intervention, wherein consumers "often must become very sick before they receive appropriate services" (MDHS). This assessment of Minnesota's mental health care system pertains directly to crisis services which should ideally address serious psychological emergencies in an effective manner.

Currently, services available to those experiencing a mental health crisis in Minnesota are lacking in both efficiency and effectiveness. A recent study by Twin Cities metropolitan hospitals with inpatient psychiatric services and emergency departments found that some 40 to 50 individuals are unnecessarily admitted to inpatient treatment due to a lack of less intensive treatment options (Olson, 2007). Additionally, nearly 250 patients per month are kept in acute care longer than needed due to a lack of residential treatment and other non-hospital based options. This totals to about 2,100 non-acute hospital days per month, translating into significant, extraneous expenditures. The hospitals involved in the study estimate that the cost of these extraneous patient days totals to nearly $24 million annually. In addition to the economic costs, unnecessary use of hospital beds means overcrowding and the increased likelihood that persons who do require hospitalization may not have access to it, an outcome which can lead to serious and

possibly deadly results. An important consideration of the Twin Cities hospital study is that it represents but a portion of hospitals in the state, suggesting that actual costs to the whole state are much higher.

Minnesota Crisis Centers

Hospital based services are not the sole provider of emergency mental health services in Minnesota. Indeed, each of the state's 87 counties is charged with providing mental health services to those within the county. With the passage of Minnesota Mental Health Act of 1987, emergency mental health services became part of the services required of each county. These services must be available 24-hours a day, 365 days a year and provide assessment and intervention. Indeed, a best-practice report on crisis centers recommends that a Comprehensive Psychiatric Crisis System (CPCS) include the following core components: 24-hour telephone lines, walk-in services, mobile crisis services, residential/respite services, and crisis stabilization units (Technical Assistance Collaborative, 2005). Nascent programs within Minnesota have attempted, with various results, to accomplish the necessary components of a comprehensive crisis service. Growing in popularity across the country, the crisis model is intended to be an efficient, mobile, flexible, and effective alternative to traditional means of emergency mental health care.

Since 2001, Minnesota mental health crisis services are billable to Medical Assistance (MA) in four general areas, each of which are integral parts of a crisis service system (MDHS, 2006). These services include crisis assessment, crisis intervention, crisis stabilization, and community intervention. Crisis assessment entails face-to-face assessment by a mental health professional after initial screening suggests that the individual may be in crisis. Crisis intervention consists

of short-term, intensive mental health treatment that is intended to return the individual from mental health crisis to their baseline level of functioning. Crisis stabilization services are intended to maintain baseline functioning and are provided in the individual's home, residential program, or other community setting and, when successfully implemented, should help in preventing future crises from occurring. Community intervention involves help with community integration and independent living. Those around the individual, such as family and friends, are included in this process which seeks to improve support systems and, along with crisis stabilization, prevent relapse (2006).

In order to bill MA in one of the four main areas of crisis services, each individual provider must be a mental health professional or be supervised by one who has had at least 30 hours of crisis service training. Most crisis centers hold in-service training on a regular basis, though training is not necessarily consistent across providers. Additional basic training is made available through the Minnesota Department of Human Services, part of which is Internet based (MDHS website). Training is available both in crisis service specific areas as well as in other topics related to mental health care. A quasi-comprehensive guide designed to aid in the establishment of a crisis response services is also made available through the Minnesota DHS. This guide addresses both macro-level administrative issues as well as specific issues which pertain to individual care providers. The extent to which this training is utilized by providers, however, is not known.

An additional qualification of crisis services in Minnesota is that they must be 'mobile.' That is, teams must be able to go on-site to the location of the mental health emergency 24 hours a day, 365 days a year. This requirement, according to the Minnesota Department of Human Services, is in keeping with best practice

(MDHS, 2006). In Minnesota and beyond, mobility is an inherent quality of any mental health crisis service, and such services often contain the term in their moniker. Mobility is an additional requirement made of crisis services in order for them to bill MA.

Presently, many of the crisis teams throughout Minnesota counties are not certified to bill MA due either to the lack of a qualified mental health professional with the requisite training or because they are not 'mobile.' Numerous Minnesota locales have had great difficulty finding practitioners willing to provide crisis services. For many areas, qualified mental health practitioners may not be available, and recruitment is often ineffective. This issue is especially salient for services which bill through MA as many providers (psychiatrists, etc.) choose not to offer their services to individuals who pay through medical assistance even where they are available. According to the U.S. Department of Health and Human Services, 54 of the 87 counties in Minnesota face a county-wide shortage of mental health practitioners, designating these counties Health Professional Shortage Areas (HPSAs) (2007). Calculating the total practitioner deficit for these 54 counties yields a total shortage of 94 mental health practitioners. This number represents only these counties; the actual shortage is much larger when partial-county shortage areas are considered.

The shortage of practitioners in many Minnesota counties is not the only confound to crisis services. Available funding and related restrictions act as an additional barrier to the establishment and success of Minnesota crisis teams. Because Medical Assistance only provides funding for face-to-face services, crisis centers face difficulties in securing enough funding to cover indirect service costs. This issue is especially relevant for rural areas where face-to-face service is relatively rare, an issue which is exacerbated by the geographic distances involved

for both consumers and those providing psychiatric services. In a crisis situation, face-to-face contact may not even be an option. Meeting MA requirements appears to be specifically challenging for these rural areas where crisis service teams are expected to provide services which are concurrently comprehensive *and* financially lean.

Best practice guidelines for mobile crisis centers recommend that a hotline be available to consumers 24 hours a day. In Minnesota, this guideline appears far from met. Among Minnesota's eighty-seven counties, some one-hundred and forty-three numbers are listed for crisis services according to the Minnesota Department of Human Services (2007). As this number suggests, there is great inconsistency in the availability of telephone hotlines to consumers in need of services. While some counties have no hotline available, others list multiple numbers with little or no indication as to which number a given consumer should contact. For Beltrami county, for instance, sixteen separate telephone numbers are listed for mental health crisis services, with each of these numbers leading to disparate service providers. Across all listed crisis service numbers, some are true mobile crisis teams, others are sheriff's offices, pager numbers, police numbers, after-hours hotlines, private entities, suicide lines, hospital numbers, and so forth. The numbers made available to the public do not lead to the same outcomes or services.

Moreover, the wide array of available numbers and apparent confusion over fit between provider type and consumer need pose yet another issue. That is, consumers are not systematically or reliably aware of the existence of such services. A resident of a given county who is experiencing a mental health crisis is likely to call 911 in lieu of a more appropriate crisis service simply because they do not know that such services are available or how one goes about contacting such services. When

consumers do contact 911, they are unlikely to be referred to an appropriate mental health crisis team.

Mental Health Training

During a mental health crisis, an individual will likely come into contact with a number of professionals who will play a role in their care. These providers include EMTs, nurses, hospital intake personnel, police, security, physicians, psychologists, social workers, and various other mental health professionals. In the critical period of mental health crisis, it is in the best interest of the individual experiencing crisis for these various providers to gather information pertinent to mental health treatment and provide appropriate and efficient treatment. Training in matters of mental health care vary widely even within a single profession, leading oftentimes to inconsistent assessment and care. Although regulatory boards and agencies do set forth some standards regarding mental health training for many health care professions, current training standards and methods continue to fall short of meeting the needs of increasing numbers of individuals requiring mental health care.

Collateral Information Gathering:

Because a person experiencing a mental health crisis may not be able to effectively communicate the nature of their mental health issues due to symptoms or lack of insight, it becomes necessary for providers to collect information from collateral sources, such as family members, friends, and others who have been in contact with the individual in crisis (American Psychiatric Association, 2006). The U.S. Department of Health and Human Services similarly recommends, through its clearinghouse of guidelines for clinical practice, that family and friends always be

utilized as a source of background information when conducting an intake or diagnostic interview. Information of this type aids in the accurate assessment of the type and severity of mental illness as well as in the selection of appropriate treatment.

Collateral information gathering applies to all of the various professionals who come into contact with the individual experiencing a mental health crisis. While information gathering is certainly important at the level of physician-patient contact, it is also of potential importance for others, such as police officers, to gather relevant information related to the individual's behavior. When factual and descriptive, this collateral information is useful to any professional who will need to make key decisions about treatment. Of clear importance are those decisions which involve whether or not to an individual is a danger to themselves or others, and whether involuntarily hospitalization is merited. Information collected at all levels of contact aid in making such important decisions.

In fact, APA guidelines for psychiatric evaluation note that the gathering of collateral information is a crucial part of all decision making and assessments in any emergency situation (APA, 2006). What remains unclear is the extent to which those involved in the provision of services to those with a mental health crisis are aware of the need to gather collateral information. While it may be safe to assume that mental health professionals such as psychiatrists and psychologists are aware of the importance of collateral information, it is unlikely that most other personnel have received such training. For instance, while psychiatrists may be aware of the importance of collateral information, emergency physicians may be less acquainted with the need to collect such information. This issue becomes important when emergency physicians and other non-mental health specialized physicians serve as

gatekeepers to mental health care in a setting where the assessment and treatment of mental illness often a low priority (Moran, 2004). In often overburdened and hurried emergency medical settings, individuals presenting with mental health concerns may receive very little meaningful contact with staff. The often meager mental health background of emergency medical staff can exacerbate the already tenuous relationship between emergency medical services and individuals in mental health crisis.

Regarding this issue, one study of a major metropolitan hospital (Lincoln & Allen, 2002) found that data from multiple sources, especially concerned third parties (such as family and friends), substantially improved the chances of appropriate hospital admittance for individuals in crisis. According to the study, third parties were able to provide meaningful information regarding the nature of the mental illness that may have otherwise been unrecognized had the attending physicians relied solely upon patient report. The researchers further note that increased legal and utilization criteria make collateral information all the more important so that barriers to care may be overcome. Additionally, they note that their findings support the use of structured methods of collecting and organizing collateral information (such as a form), which in turn can become part of a person's medical records. Use of a structured form would be among the procedures that would help systematize the gathering of information at all levels of care.

While issues concerning the collection of collateral information applies to a wide variety of professionals who serve those with a mental health emergency, there are a myriad of issues which apply to specific service providers. The following sections outline the general training received regarding mental illness by practitioner type.

Physician Training:

Typically the primary service provider responsible for the diagnosis and treatment of mental illness, especially by way of medication, physicians vary greatly in their mental health training. Traditionally, psychiatrists have been utilized to meet the needs of those facing a mental health emergency. In a traditional model of care, a psychiatrists would be available in an emergency care setting should assessment indicate that a referral to the specialty is indicated.

Though psychiatrists are the physicians with specific training and specialization in mental health care, making them best suited to handle such issues, increasingly more general practitioners and internists are taking on the treatment of those with mental health concerns, including those with severe mental illness (Daly, 2006). Daly speculates that because primary care physicians have become "gatekeepers" for access to specialized medicine, they are themselves treating even major mental illnesses when in the past a referral to a specialist would likely have been made. As a result, assessment of mental illness is increasingly conducted by physicians who may not have the background to fully gauge or effectively diagnose mental disorders. Moreover, the study indicates that this pattern of decreased utilization of specialized mental health care may result in lower treatment adequacy. Because these physicians often lack a comprehensive (or even adequate) background in the treatment of mental disorders, they are more likely than their specialized counterparts to prescribe inappropriate or insufficient treatments. In emergency mental health situations, the likelihood is ever higher that the attending

physician will have very little background and perhaps no ongoing training in the assessment and treatment of issues related to mental health care.

EMT Training:

Given the nature of mental health emergencies, many individuals experiencing a mental health crisis will initially come into contact with emergency medical technicians (EMTs) and other front line health care professionals. Whether or not EMTs and related professionals are prepared to effectively deal with individuals undergoing crisis depends on a number of factors, prime among these being mental health training. In Minnesota, there are three levels of certification for EMTs: basic, intermediate, and paramedic. Training for these levels of certification follows the standard curriculum set forth by the U.S. Department of Transportation. At a minimum, curriculum for basic certification entails 110 training hours. Hours and experiences do vary, however, with some programs providing up to 140 hours of training. Variance in training is likely due to the number of programs- approximately 80 – certified to provide EMT training in Minnesota. Providers of EMT training include hospitals, private businesses, post-secondary schools, and various other entities. These disparate entities offer varying degrees of mental health training, which, though in accordance with federal regulations, may not produce equally well prepared emergency medical professionals.

Though EMT education may differ by provider, there is some relative consistency to curriculum. In the required 110 hour training period, a wide breadth of topics and practical skills are covered. Behavioral emergencies, which are included alongside medical emergencies and obstetrics in the third training module of the EMT curriculum, entail a recommended 2 hours of classroom education. Such

emergencies may be further addressed during an 8 hour lab which covers all topics covered in the third training module. The actual amount of time spent, as well as the depth of lab training, varies by program. Competence of the curriculum from the third module and lab, including behavioral emergencies, is determined by a 1 hour comprehensive evaluation.

Police training:

Police officers are frequently first-responders for mental health crises. They are often called upon to intervene in and provide assistance to a wide variety of individuals in some form of mental health emergency, from relatively minor situations involving medication or erratic but benign behavior to sometimes dangerous situations concerning persons who may be a threat to themselves or others. Where other crisis intervention services do not exist or where the community is unaware of them, 911 often becomes the default source of assistance with crisis situations. As such, police involvement in mental health emergencies is an important issue for any community. Depending on their actions, police presence can aggravate as well as diffuse a crisis situation.

To help police play a beneficial role in such situations, a number of locales have addressed both this issue and the increasing need for mobile mental health crisis teams by way of police training (Steadman, Deane, Borum, & Morrissey, 2000; Teller, Munetz, Gil, & Ritter, 2006). With a police-based intervention model, often in the form of CITs (crisis intervention teams), specialized police units are trained in issues related to psychiatric emergencies in hopes that they will be better prepared to de-escalate crisis situations than traditionally trained officers. Traditional police

procedure can be jarring and detrimental to persons with a mental health emergency, making specialized training an effective alternative.

Other Care Providers:

A number of other relevant service providers are likely to come into contact with individuals experiencing a mental health crisis. These providers include nurses, hospital security personnel, social service providers, and other social and health care professionals. In a mental health emergency, for instance, it is possible that the actions of an emergency room security guard could act to either calm or exacerbate the behavior of an individual seeking emergency care.

At the time of this assessment of crisis services in Minnesota, no meaningful data gathering of nurse training was possible. Attempts to obtain information regarding nurse training and standards in the area of mental illness were unsuccessful. Training assessments of personnel such as security guards was not attempted for the purposes of the current study. Future studies should seek to obtain data related to nurse training as well as training for other relevant staff in issues related to mental health

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Evaluation of Police-Based Crisis Intervention (CITs)

As discussed in the section on police training, many locales have endeavored to provide police with supplemental mental health crisis training. In response to increasing need for crisis intervention, a number of locales have gone even further in service of effective intervention by creating police-based crisis intervention teams. County or city based programs in some areas have developed specially trained units

which are available at all times to respond to a mental health related emergency. Still others have prepared police intervention units by pairing trained officers with a mental health professional. These teams seek to deescalate crisis situations as well as assess whether an individual requires contact with one of a number of mental health care providers.

Current research regarding police crisis intervention teams (CITs) supports their effectiveness over traditional police intervention. One study of a police mobile crisis team in DeKalb County, Georgia, which includes part of the Atlanta metro area, found that mental health related emergencies handled by mobile crisis teams resulted in hospitalization 45% of the time, while emergencies handled by the police led to hospitalization in 72% of cases (Scott, 2000). This statistically significant difference indicates that trained mobile crisis teams may be better equipped to resolve a crisis situation without requiring eventual hospitalization for the consumer. Of those cases which did require hospitalization, involuntary hospitalization occurred 36% of the time with the mobile crisis teams compared with 67% of the time for traditional police intervention. Due to outcome incongruity between mobile crisis teams and traditional police intervention, resulting costs likewise differ significantly, with mobile crisis services costing 23% less per each case. Because police CITs consistently deescalate and more efficiently resolve crisis situations, the resulting level of care for the individual in crisis is more appropriate and the overall cost lower.

In neighboring Alabama, an innovative police-based crisis intervention program in Birmingham has likewise produced positive results. The Birmingham CITs incorporate civilian community service members trained in social work and related fields alongside specially trained police officers (Steadman, Deane, Borum, & Morrissey, 2000). These teams seek to resolve mental health crises on scene, with

mental health professional team members providing follow-up and other services as needed. Notably, these crisis intervention teams have shown great ability to resolve mental health crisis situations at the point of contact. Nearly two-thirds of crisis team calls in Birmingham resulted in resolution and de-escalation on the scene without the need for hospitalization. This result reflects a significant improvement for police involved crisis resolution of mental health emergencies over Birmingham's previous traditional police model.

Specially trained crisis intervention teams were likewise established in Akron, Ohio. As in Georgia, Akron CITs developed a unit of specially trained officers who were made available to respond to calls involving mental health crisis. A recent study examined the effectiveness of the Akron CITs using ANOVA to assess the effectiveness of crisis team training (Teller, Munetz, Gil, & Rutter, 2006). Among the findings was that, after training, CIT officers were significantly more likely to transport individuals on mental health related calls to emergency psychiatric services and other treatment facilities when appropriate than their untrained counterparts. Moreover, those without CIT training were significantly more likely to fail to transport these individuals anywhere after interacting with them on a call, effectively leaving a portion of individuals in need of treatment without any. The findings overall indicated that trained officers were more likely to provide meaningful intervention after receiving a mental health related call.

In addition to differences in intervention level by training, the Akron study also found that family members report being more comfortable calling the police to request help with a family member after CIT training was implemented. Prior to implementation of CITs, families of individuals with mental health crises reported lower levels of satisfaction with police intervention outcomes and were thus less

likely to seek police assistance. Indeed, CIT training increased both the number and proportion of calls recognized as potentially involving a person with a mental illness (Teller, Munetz, Gil, & Ritter). Because the trained crisis intervention teams offered a more effective and understanding service, persons in need and their families grew more likely to seek help when it was needed.

Use of police for mobile crisis intervention is not always a stand alone solution for mental health crisis needs. Rather, police training may be part of a larger mental health crisis care model that includes more traditional means of crisis intervention and care. As a discrete entity, police-based crisis teams do not necessarily address issues such as stabilization and housing, facets of crisis services that are required in Minnesota as well as elsewhere. However, studies do indicate that use of specially trained police teams have been effective at the intervention level. Research has consistently highlighted the comparative advantage that specially trained crisis intervention teams have over traditional police interventions. Some Minnesota communities have implemented CITs or some variation thereof. Minneapolis, for instance, makes use of specialized training to better prepare officers for interventions involving persons with mental illness.

Evaluation of Mobile Crisis Teams

Either in cooperation with police or as a separate entity, mobile crisis teams seek to provide quality services in the four primary areas of crisis services. Though they vary in composition and procedure by locale, mobile mental health crisis teams are generally regarded as an important element for comprehensive mental health services. Among the arguments in favor of mobile crisis teams is that they reduce psychiatric hospitalization, thereby also reducing associated costs. One study

compared hospital and mobile crisis team outcomes through a quasi-experimental design with a matched-sample of 2,200 adults (Guo, Biegel, Johnsen, & Dyches, 2001). It found that mobile crisis team intervention led to hospitalization 8 percent less frequently than traditional hospital based interventions. Moreover, individuals utilizing mobile crisis services were 51% less likely than those using hospital based services to require hospitalization within 30 days following their mental health crisis. This particular finding indicates that mobile crisis teams provide a degree of treatment generalization and stability that is found significantly less often in hospital based treatments.

In another quasi-experimental assessment of mobile crisis teams in England, researchers found results similar to those from American studies (Johnson et al., 2005). Significant differences were noted in the hospitalization rates between groups six weeks following the mental health crisis. Moreover, a significant result was also found in the mean and median satisfaction ratings given by the two groups. The median rating for those served by traditional, hospital based services was "mildly dissatisfied," while the median satisfaction rating for those served by the crisis response teams was "very positive." Though findings related to client satisfaction may not generalize well to other localities, they do suggest that well conceived crisis response models may provide consumers with a superior quality of experience relative to traditional, hospital based services. Moreover, greater consumer satisfaction with mental health services positively impacts the likelihood that individuals in mental health crisis, as well as their family and friends, will seek out crisis services.

Another important issue to crisis services relates to the mental health needs of children and adolescents. Currently, many locales have established separate

systems of mobile crisis services for adults and children. In Minnesota, adult care providers and data regarding their intake and outcomes are separate from the services made available to children in mental health crisis. The providers themselves, privately of publicly run, do differ in this regard, however. While many providers focus on crisis care for adults only, others provide services to both adults and children. Related to previous discussion of Minnesota services, the public is likely unaware of which of the 143 crisis service providers in Minnesota are set-up to handle the needs of children.

Baltimore Model:

Among the more effective models for crisis services is that of the Baltimore County Crisis Response System (BCCRS). Based on survey based interview data as well as both public data and empirical research, the following section details the Baltimore model of mental health crisis services.

Serving the greater Baltimore area since its formation in mid-2001, the system has been awarded the National Association of Counties Award for innovative services. A collaborative program between the Baltimore County Police Department, the Baltimore County Health Department and Affiliated Sante Group, the cooperative partnership was created to provide comprehensive crisis intervention services to persons experiencing all variety of mental health crisis. Currently, the service handles approximately 12,000 calls per year. The Affiliated Sante Group is a private consultant which provides service assistance with crisis centers nationwide. They currently work with other services in the Maryland/Washington D.C. area as well as one county in North Carolina.

The BCCRS program seeks to address all primary areas of crisis service needs. As such, the system overall is divided into Home Intervention Teams, Urgent Care Clinics, Critical Incident Stress Management, and Mobile Crisis Teams. In addition, a single access point in the form of a telephone hotline is available for the entire geographic area served. Not only is the entire service region accessed by a single hotline phone number, but calls to 911, when appropriate, are routed to th services provided by the BCCRS. Additionally, as with most other crisis service models, police play an important role and are thus involved with the crisis teams, where officers are paired with a mental health clinician to provide intervention to persons in need of emergency services. The public is made aware of the services provided by the BCCRS by way of a comprehensive marketing campaign. The services are marketed through presentation at local venues (such as churches, providers, hospitals etc), information postings, radio, brochures, phone books, websites. The hotline for BCCRS is also provided by a large number of after-hour phone messages at clinics and local advocacy groups.

The BCCRS, in line with best practice for comprehensive crisis services, is intended to meet a number of goals. General goals involve issues related to improving consumer satisfaction with services and filling the needs of those people who most frequently require mental health services. Other goals are police related and involve issues such as fostering partnerships between police and the mental health system and increasing effectiveness and efficiency of police involvement on mental health related calls. Other goals are related to emergency health services and involve issues such as improving access to coordinated psychiatric emergency services, fill gaps identified in other emergency services, and appropriately divert people in need of mental health services from hospital emergency rooms and 911

services. According to the BCCRS, the system has been effective in diverting consumers from local hospital emergency rooms though hard data to this effect has not yet been established.

The divisions of the BCCRS were developed with the intention of meeting the system goals. The single-access point hotline is managed by a 24-hour operations center which is staffed by mental health professionals and functions as a clearing house for information and referrals, suicide prevention line, and center for assessment and triage. The In-Home Intervention Teams are comprised of mental health clinicians (as well as police as needed) who stabilize and deescalate crisis situations, decrease the need for hospitalization, and refer to appropriate resources. Urgent care clinics provide one-time assessment by licensed therapists or psychiatrists to individuals who require some form of emergency mental health service. Critical Incident Stress Management Teams provide volunteer staff who partner with police team members to assist in mental health related police contacts during emergency management situations. Mobile Crisis Teams pair Master's level clinicians with plain-clothes police officers for the provision of on-site crisis response. These teams operate 16 hours a day, seven days a week and provide immediate assessment, crisis resolution, education, and referral when needed. The Mobile Crisis Teams go on-site to between 50 and 70 calls each month.

Recommendations

Based both on the needs identified in mental health crisis services provided in Minnesota and on the elements of successful models from other locales, the following section outlines recommendations for possible changes to status quo service provision. The recommendations include:

- Train all relevant service providers in the collection of collateral mental health information.
- Use of a standardized form to proffer reliable documentation of collateral mental health data.
- Assess mental health awareness of general practice physicians and provide supplemental training as needed.
- Provide relevant, on-going mental health training for EMTs and other first-responders, including police officers.
- Establish units within police departments consisting minimally of officers specially trained in dealing with persons experience a mental health crisis and crisis de-escalation.
- Make available a single entry point in the form of a hotline of other number (i.e. 211) which serves all individuals experiencing a mental health emergency within a large geographic area.
- Coordinate between counties and service providers to centralize services and share resources to ensure proper coverage when needed.
- Initiate a public awareness campaign regarding the availability of mental health crisis services and how and when to contact them.
- Assess effectiveness of crisis service intervention versus traditional intervention by way of consumer satisfaction surveys as well as by systematic cost/outcome comparison.
- Establish stabilization and other relevant after-care services.

These recommendations are not meant to be exhaustive of the many changes which could be made to current mental health crisis services in Minnesota. Instead, they are meant to highlight some of the clear deficits in the status quo, in doing so culling from the successful aspects of other models. Regarding training recommendations, many resources are already in place to bolster existing training of providers. The state of Minnesota currently offers workshops as well as web-based training regarding mental health issues and even provides some specific training for certain professions, such as EMTs. Few changes would be needed to simply ensure

that current resources are fully utilized. Additional training for police officers, emergency room staff, and other relevant professions could be likewise offered by way of the internet as well as through outside training by advocacy groups and the like. One key element to training is ensuring that it occurs systematically and includes all providers regardless of affiliation.

The need for collateral information gathering is likewise an issue related largely to training. Collection and use of collateral information could be included in current training curriculum. Implementation of a standardized form for collateral information would likely need to be implemented by individual providers. However, incentives do exist for use of such forms. Service providers would likely find that their system offers more effective assessment and care. Additionally, standard collateral data collection would allow for more streamlined record keeping, which itself provides some legal protection to health care providers.

Though positive changes have occurred, police training and involvement in crisis services remains inconsistent throughout the state. Minimally, police and sheriff departments should provide additional training for officers in relevant mental health information and crisis de-escalation. Establishing police crisis teams such as those found in Memphis and Baltimore would require additional resources which may not be available to all locales. However, empirical evidence indicates that police based crisis intervention frequently demonstrate greater effectiveness in a number of areas over traditional approaches.

Having a single entry point for consumers in need of services is among the most important of the recommendations set forth in this monograph. Successful models of care in other areas typically make a single number available to the entire coverage area. The current array of available contact numbers and services

available to Minnesotans makes for a disjointed and confusing system of care. Survey work should be conducted to establish to what extent the public is aware of the existence of mental health crisis services. Preliminary evidence suggests that awareness is quite low throughout the state. Even if we assume that the public is aware that such crisis services exist, it is unlikely that they know which of the many numbers to contact when a mental health emergency arises. Once a single entry point is established, the number and the services it links to should be marketed widely to the population it serves. Doing this will not only ensure service utilization, but it will also begin the process of diverting individuals from hospitals and other general medical care providers.

In line with providing a single entry point, current services, when possible, should be merged to improve efficiency and coverage. This is especially important for rural areas where coverage areas are large and resources scant. If multiple providers can share resources, they will likely be better equipped to provide services in the four primary areas of crisis services, qualifying them for medical assistance billing.

In general, counties in Minnesota, either in collaboration with other counties or alone, are able to establish the various elements of a best-practice crisis service system. The legislation and funding is, to an extent, already available. Though not available for a full 24/7 service (which would be considered best practice), money is available for a number of crisis service elements. Moreover, existing providers could be merged, services streamlined, and collaborations formed between necessary service elements. Systematic training could be readily established by better utilizing existing resources. Other changes, such as collecting collateral data and requiring ongoing mental health specific training, would pose relatively minor costs to

providers. Though positive and efficacious major changes could be made throughout the state in regard to mental health crisis services, there are a number of smaller improvements available to the current system at all levels.

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APPENDIX

I. General Survey for provider interview

Crisis Center specific issues:

How is the public made aware of the existence of crisis centers? How is awareness assessed?

How are crisis centers contacted? Have there been attempts to establish a single access point?

What are the primary reasons given for contacting crisis centers?

To what extent is there overlap, where individuals are seen both in a crisis center and a hospital emergency room?

What is the approximate cost of running a crisis center? (per population served) How are crisis centers funded and what is the breakdown of funding sources?

What, if any, changes will be made to improve access to crisis centers?

Training issues:

From where do crisis center/ER staff members currently receive their training in psychiatric emergencies? (specific, separate training for various positions, i.e. EMTs, nurses, security)

What does training entail?

Are staff members trained to collect relevant information from the family and friends of the individual in crisis?

Other issues:

What geographical area is served by the crisis center/inpatient unit/ER? (alternatively, what are the zip codes of those served?)